STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CLARE BRIDGE OF WICHITA	9191 E 21ST ST N WICHITA, KS 67206

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S 000	INITIAL COMMENTS The following citations at the above named facility represent the findings of resurvey with complaint #85900 at the above named facility on 4-9-15, 4-13-15, 4-14-15, 4-15-15 4-16-15, 4-20-15, 4-21-15, 4-22-15, and 4-23-15.	S 000		
S3026 SS=G	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility identified a census of 27 residents. The sample included 3 residents and 3 focus review residents. Based on record review, interview, and observation for 1 (300) of 3 residents sampled, For resident #300, the operator failed to ensure resident not subjected to neglect when licensed nurses failed to thoroughly assess the resident when resident experienced a changed in condition beginning on the night of 4-10-15. After the resident was identified with a nondisplaced hip fracture on 4-13-15, the licensed nurses further failed to implement interventions to address care of Resident #300. He/She was found on the floor the following day and suffered a displaced fracture of the femur	S3026		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S3026	Continued From page 1 and bilateral sacaral ala fractures. Findings included: - Record review for resident #300 revealed an admit date of 1-31-15 with diagnoses of vascular dementia, atrial fibrillation, anxiety, and on 4-13-15 new diagnoses of osteoarthritic changes and non-dislocation sub capital right hip fracture. The Functional Capacity Screen (FCS) dated 2-2-15 (admit) recorded resident #300 was independent with cognition, communication, no falls/unsteadiness, experienced impaired decision making, required supervision with walking/mobility, eating, required physical assistance with bathing dressing, toileting, transfer, and management of medications/treatments. The Negotiated Service Agreement (NSA) dated 2-3-15 recorded provided assistance with medications, assist with dressing, shower, toileting, needs reminders and shown where activities are but able to ambulate on own. Resident does have a wheeled walker used on occasion. Resident needs assist because of memory loss, not always oriented to place, time, and does not always recognize family member. Resident record documented a noninjury fall on 3-6-15 and documented on 3-8-15 that resident enjoyed roaming freely in the building. The FCS dated 3-27-15 (30 day) recorded resident independent with eating, required supervision with walking/mobility, transfer, required physical assist with bathing, dressing, toileting, management of medications/treatments, incontinent of bladder and bowel, and	S3026		

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S3026	Continued From page 2	S3026		

experienced impaired short-term memory, long-term memory, memory recall and decision making. The FCS lacked documentation of falls/unsteadiness, impaired decision making, and wandering as current or recent problems.

The NSA dated 3-27-15 recorded staff to administer all medication, independent with eating, requires assistance with dressing and grooming needs, bathing (shower), incontinent care as incontinent of bowel and bladder. Staff to escort to activities and meals due to memory impairment and resident use of walker as mobility aide, needs reminders and shown where activities are but able to ambulate on own. The NSA/HSP lacked documentation of interventions for falls.

Observation on 4-9-15 at 3:55 p.m., resident #300 ambulating throughout the facility without difficulty. Observed several bruises on left arm. Licensed nurse A stated resident fell on 3-26-15. On 4-9-15 at 5:40 p.m. observed resident ambulating down hallway by self.

Resident record lacked documentation or notification of family and physician of change in condition noted on 4-10-15, 4-11-15, and 4-12-15.

Staff statements recorded the following:

" Resident was walking around community on 4-9-15 and 4-10-15 with no difficulty. Resident had no complaint of pain when I spoke with resident. Resident had a shower on 4-9-15, no report of pain at this time. " written witness statement from licensed nurse A completed on 4-15-15.

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S3026	Continued From page 3 " I went to put resident to bed on Friday night (4-10-15). (Licensed nurse F) had taken resident to the restroom and resident did not want to get up so I came back and took resident to bed. Resident did not complain of any pain. " written witness statement from certified staff I completed on 4-14-15. " On the night of Friday April 10th rounds were done. Resident was lying in bed asleep. Resident was checked every hour for visual and every two hours for incontinent care and to use the restroom. Resident did not void all night and refused to use restroom when asked. At 5:00 a.m. resident was found lying in bed and legs hanging off right side of bed complaining of upper abdomen pain. [Licensed nurse J] was call to the room and assisted resident to lay in bed with legs straight. Pain pill given and resident refused to go to restroom. " written witness statement from certified staff G completed on 4-14-15. " At 5:30 a.m. (on 4-10-15) staff [certified staff G] came to me to report resident complained of leg pain. . . . Resident was assessed. No injuries or bruising noted at this time to indicate a fall or any other incident. Report was given to oncoming nurse about resident complaint of pain and Tylenol given. " written witness statement from licensed nurse J completed on 4-15-15. Telephone interview on 4-16-15 at 11:20 a.m. with licensed nurse J stated, " Works the 10:00 p.m. to 6:00 a.m. shift. Worked Friday night (4-10-15) to Saturday morning (4-11-15) until 6:10 a.m . Resident #300 slept during night and about 5:30 a.m. had edema in lower extremities. Resident wanted to stay in bed and did not want to get up. . Resident just wanted to rest and did not document anything in the record. "	S3026		

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S3026	Continued From page 4 " On Thursday 4-9-15 when I left this resident was walking around fine and doing his/her normal thing. When I returned to work on Saturday 4-11-15 I went to assist another aide in getting resident out of bed and resident said he/she was hurting and did not want to get up. Throughout my entire shift resident refused to get out of bed and he/she was still hurting. The [licensed nurse B] was aware of this. " written witness statement from certified staff H completed on 4-14-15. " (On 4-11-15) Received report from the night shift nurse [licensed nurse J] that resident was having leg pain and a Tylenol was given. On initial assessment of resident he/she was lying in bed resting. Resident did stated had some achy and soreness present. Both legs appeared to be swollen at this time. Resident has swelling very often in lower extremities. . . No bruising or injuries noted at this time. Resident was checked for normal range of motion and resident was within normal limits. Resident requested to stay in bed to rest. Reported to second shift aide [certified staff K] of resident condition. " written witness statement from licensed nurse B completed on 4-15-15. Telephone interview on 4-16-15 at 10:50 a.m. with licensed nurse B stated, " Resident was sore throughout the night and complained of pain on 4-11-15. Tylenol was administered. . . on 4-11-15 and 4-12-15 resident just stayed in bed. Resident acted like he/she was tired. Nothing given for discomfort. Licensed nurse B further stated he/she did not think about resident having a fracture or anything. Resident just did not come out to walk and staff toileted him/her. I did not document anything in the record. " Licensed nurse B confirmed resident usually ambulated all	S3026		

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S3026	Continued From page 5 the time. " I went to resident room to get him/her up for breakfast (on 4-12-15) and he/she said his/her legs hurt and was not hungry. Resident did not want to go to the restroom. I left and told the [licensed nurse B] the resident was complaining of pain. " written witness statement from certified staff C completed on 4-12-15. Resident log notes documented: 4-13-15 at 1:24 p.m., " Received a call from resident ' s family to inform while visiting on Saturday and Sunday, resident appeared lethargic and was hesitant to get out of bed. " Signed licensed nurse D. 4-13-15 at 1:30 p.m., " Resident alert and oriented to name and responsive to verbal and tactile stimuli. Resident denied pain and denied a fall. Resident has range of motion normal limits with left extremities per self. Facial grimace upon range of motion to right lower extremity, resident would not bear weight, move, or lift right lower extremity. No external rotation or shortening present. " Signed licensed nurse D.4-13-15 at 1:35 p.m., " Call placed to physician to obtain orders for x-ray of right hip, pelvis, and obtain a urinalysis. " Signe licensed nurse D. 4-13-15 at 2:10 p.m., " Staff assist times 2 (two person transfer) with wheelchair to resident ' s room. Resident does self-propel with both feet, however must have two person assist with lifting. Still does not bear weight on right lower extremity{femur}, noted. " Signed licensed nurse D.	S3026		

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S3026	Continued From page 6 4-13-15 at 4:14 p.m., " Radiology technician has arrived for mobil x-ray. " Signed licensed nurse D. 4-13-15 at 5:00 p.m. " . . . Resident continued to deny pain, yet grimaces upon movement. " Signed licensed nurse D. 4-13-15 at 5:50 p.m., " Staff to allow resident to rest in bed, complete rounds every two hours and keep call light in reach. " Signed licensed nurse D. 4-13-15 at 6:00 p.m., " Received radiology report from radiologist. Spoke with resident, family member and physician. The physician rendered two options for treatment. Send to hospital of choice or treat in house. " Signed licensed nurse D. 4-13-15 at 6:20 p.m., " (family) does not want resident removed from current placement and prefers that resident received treatment within the community.. . . " Signed licensed nurse D. 4-13-15 at 6:31 p.m., " Telephone orders for hydrocodone 5/325 milligrams (MG) every six hours as needed for pain. Physician therapy evaluation and treat, bed rest for three weeks and continue to monitor. " Signed licensed nurse D. The NSA/HSP lacked interventions to address care of non-displaced hip fracture. Mobil x-ray results dated 4-13-15 for fall recorded the following: Right Femur: Multiple views of the right femur obtained on 4-13-15. There is a fracture involving	S3026		

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the proximal femur at the level of the sub capital region. Slight angulation of fracture site. No dislocation.
Impression: 1.) Recent sub capital right hip fracture.

Observation on 4-13-15 at 1:00 p.m., 2 skin tears on left arm with six areas of bruising from elbow down arm. Resident unable to ambulate at this time. Resident sitting in wheelchair in dining room.

The resident log notes recorded:
4-14-15 at 6:20 a.m., " . . .Resident complained of pain all over. Tylenol 650 MG administered for pain. Resident is kept non-weight bearing. Will continue to monitor. Call light in reach. " Signed licensed nurse E.

4-14-15 at 2:15 p.m., " Spoke with physician regarding right hip fracture and was informed as long as pain is managed resident can remain in community. Resident is to remain non-weight bearing but can be assisted by two staff to wheelchair for meals. " Signed licensed nurse A.

4-14-15 at 6:00 p.m., " Resident lying on the floor in apartment on left side at approximately 4:40 p.m. when call by staff to resident ' s room where resident was alert and oriented to self, did not move resident. Asked resident if he/she hit his/her head and stated yes on the floor. . . . Resident stated was going to get something to eat. Resident observed by certified staff at approximately 3:50 p.m. for incontinent care, resident was dry and resting in bed with eyes closed. . .911 called to send to hospital. Family notified. Physician notified. 5:00 p.m. EMS exited the facility. On coming nurse will be

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S3026	Continued From page 8 informed of resident incident. " Signed licensed nurse F. Hospital CT Scan on 4-14-15 of abdomen and pelvis with contrast: Indication: Injury from a fall. Findings: There appear to be bilateral sacral ala fractures. There is a right femoral neck fracture. Impression: 1.) Right hip fracture. Sacral ala fractures of indeterminate age. Observation on 4-14-15 at 12:25 p.m., licensed nurse A turned and repositioned resident #300. During repositioning resident identified with facial grimacing as in pain and placed hand on right hip. For resident #300, the operator failed to ensure resident not subjected to neglect when licensed nurses failed to thoroughly assess this cognitively impaired resident when resident experienced a change in condition beginning on the night of 4-10-15. After the resident was identified with a nondisplaced hip fracture on 4-13-15, the licensed nurses further failed to implement interventions to address care of Resident #300. He/She was found on the floor the following day and suffered a displaced fracture of the femur and bilateral sacaral ala fractures.	S3026		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator	S3028		

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S3028	Continued From page 9 or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3) The facility identifed a census of 26 residents. The sample included 3 residents and 6 focus review residents. Based on record reviews, interviews, and observations for 1 (#200) of 3 residents sampled, the opertor failed to report allegations of abuse/neglect to the department within 24 hours, start an investigations, implement immediate measure to prevent further potential abuse/neglect, thoroughtly investigate	S3028		

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within 5 working day of the initial report, take corrective action, submit the department's complaint investigation repport within 5 working days, and a written record shall be maintained of each investigation of reported abuse or neglect.

Findings included:

- Record review for resident #200 revealed an admit date of 2-16-15 with diagnoses of organic dementia, depression with anxiety, hypertension, and osteoarthritis.

The functional capacity screen (FCS) date 2-17-15 recorded resident independent with transfer, walking/mobility and did not exhibit socially inappropriate behaviors. The FCS also recorded resident required physical assistance with bathing dressing, toileting, eating, management of medications/treatments, bladder incontinence, experienced short-term memory loss, long-term memory loss, memory recall, decision making, impaired decision making, falls/unsteadiness, and wandering.

The Negotiated Service Agreement (NSA) dated 2-17-15 recorded resident required physical assistance with bathing, dressing, toileting, eating, staff to administer medications/treatments. Resident is incontinent of bowel and bladder, independent with all transfer and mobility. Resident needs redirection to the dining room for meals and to game room for activities. Resident has memory impairment, wanders and requires redirection. Resident is not oriented to person place and time. Resident has difficulty communicating needs, preferences, and wanders throughout the facility down the halls and in common areas. Resident is easily redirected. Resident demonstrates reluctance for

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. . accepting care, is combative at times and starts breathing heavily before becomes combative. When resident non-compliant or combative, staff is to step away and re-approach at a later time.

The NSA lacked revision to address aggressive behaviors or difficulty redirecting, hitting, kicking, pushing, and grabbing other residents and staff.

Resident #200 ' s log notes recorded the following:

2-17-15 at 4:00 p.m., " Resident walking halls most of time. . .Resident did show combative behaviors when staff approached to try and toilet resident. Resident is not oriented to person, place, or time. Resident ' s spouse stated this is the behaviors resident had at home. " Signed licensed nurse L.

2-18-15 at 6:40 a.m., " . . .Resident redirected throughout night to room. On resident ' s last check and change (resident) charged at this nurse and attempted to hit when assisting him/her to bed. Attempted to administer Ativan as needed (for anxiety) and resident refused. " Signed licensed nurse E.

2-21-15 at 7:15 a.m., " Resident charged this nurse and two other staff members with a chair. Resident attempted to enter into other residents rooms. Resident does not take re-direction well and attempts to hit staff with open hand. New order for Ativan topical every 6 hours for anxiety. " Signed licensed nurse B.

3-2-15 at 4:30 p.m., " Resident #200 grabbed resident #400 ' s hand squeezing it very tight causing the resident to scream, associates

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intervened and got resident #200 to free resident #400 ' s hand. Resident taken to dinner and attempting to hit associates while being seated. " Signed licensed nurse A.

Note: Negotiated service agreement dated 6-25-14 for resident #400 recorded resident independent with ambulation using for wheeled walker. Resident very pleasant and social. Resident has memory and decision making impairment, short and long term memory loss with impaired decision making. Resident #400 ' s record lacked documentation of assessment following 3-2-15 altercation with #200.

Resident #200 ' s log notes further recorded: 3-3-15 at 11:30 a.m., Resident very resistive to care and combative with associates. Multiple attempts to re-direct resident were unsuccessful, resident remained combative and agitated. Signed licensed nurse A.

3-4-15 at 6:50 p.m., " Resident displayed severe aggression towards staff during life enrichment activity. " Signed licensed nurse D.

3-9-15 at 6:50 p.m., " Resident ambulating throughout community with unsteady gait, refused staff assistance. Resident continued to display combative behaviors towards staff and residents. Resident redirected several times. " Signed licensed nurse D.

3-14-15 at 7:58 p.m., " Resident is re-directed as he/she is in another resident ' s room lying on floor. Resident became combative with staff by hitting, punching, squeezing fingers, bending arms, and running. " Signed licensed nurse D.

3-14-15 at 8:50 p.m., " Resident refused to leave

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S3028	Continued From page 13 other residents alone and continued to hit staff when re-directed. " Signed licensed nurse D. 3-15-15 at 4:20 p.m., " Resident became combative with another resident #700 by twisting his/her arm. Resident refuses to ambulate to activity without hitting staff. " Signed Licensed nurse D. Note: functional capacity screen dated 1-22-15 for resident #700 recorded resident independent with ambulation, experienced short term memory loss, long term memory loss, memory recall and impaired decision making. Resident was not at risk for wandering or falls/unsteadiness. Resident #700 ' s resident log notes lacked documentation of an assessment at the time of the incident; entry dated 3-16-15 at 4:10 p.m. recorded resident ambulating halls without difficulty. Resident has a large dark purple bruise to right posterior forearm, large purple bruise to right hand, dime size bruise to left hand, and approximately bigger than a quarter size bruise to left hand that looks old. Signed licensed nurse A. Resident #200 ' s log notes further recorded: 3-16-15 at 4:30 p.m., " Around 1:45 p.m. this resident became aggressive with another resident #500 after he/she tried to hold his/her hand. This resident hit him/her on the left side of his/her back and pulled his/her hair. Associate intervened and separated them. Multiple attempts to redirect were unsuccessful. Resident hitting out at associates. Ativan was given. " Signed licensed nurse A. 3-17-15 at 12:30 p.m., " . . . Resident kicks and hits staff. Resident allowed to ambulate without shoes to enhance safety. " Signed licensed nurse D.	S3028		

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S3028	Continued From page 14 4-7-15 at 3:45 p.m., " Called to resident room by certified staff who heard screaming noise and found resident #200 in resident #100 ' s room sitting in the recliner. Physician notified of resident #200 ' s behavior. Resident is monitored by staff at all times, staff continue to close all room doors to ensure safety of all residents. " Signed licensed nurse D. Review of resident #100 ' s record at 4:20 p.m. revealed an admit date of 9-17-14 with diagnoses of non-insulin dependent diabetic and arthritis. The Functional Capacity Screen (FCS) dated 9 2-24-15 recorded resident was independent with transfer, walking/mobility and had occasional short term memory loss. The FCS dated 2-24-15 recorded resident not at risk for falls/unsteadiness and does not experience impaired decision making. Interview on 4-9-15 at 3:35 p.m. with resident #100 stated he/she " moved here with his/her spouse who passed away last week. Resident stated resident #200 opened his/her door and came in while he/she was sitting in recliner. He/she got up and told resident #200 this was not his/her room and to leave. He/she turned around and asked him/her to leave and walked towards the door and resident #200 pushed him/her down to the ground where he/she fell face first to the floor. Resident #200 put his/her foot over (resident #100 ' s) head to keep resident down on floor and told him/her to shut up. Resident #100 started screaming as loud as he/she could and staff came to room to get resident out his/her room. Resident #100 was bleeding from nose and small area at bridge of nose where glasses was. " Observed red spots the size of an open hand on floor where resident stated he/she fell.	S3028		

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Resident #100 stated that was his/her blood from the fall. Resident #100 further stated the facility called EMS and 911. Police arrived prior to EMS arriving. Family member arrived prior to EMS/police leaving. EMS assessed resident #100 who declined going to the Emergency Room at this time.
Observed purple bruising around nose, left eye, left cheek from eye down to under neck. Bruising also noted to right and left knee approximately 3 centimeter circle purple in color. .

Interview on 4-9-15 at 2:38 p.m. with operator stated, resident #100 was pushed down by resident #200 who has impaired memory. Resident #100 has bruising on face, left cheek, eye and nose. 911 was called and police came and did a police report. Family (for resident #100) was upset and felt resident #200 was stalking resident #100. Further stated resident #200 does grab other residents and staff. He/she has grabbed other resident ' s wrist and he/she is a big person.

Resident #200 ' s log notes further recorded: 4-9-15 at 6:00 p.m., " Licensed nurse A called an outside agency that provided 24 hour sitter due to resident #200 ' s previous aggression towards resident #100. The agency will send a sitter this evening. " Signed licensed nurse A.

4-9-15 at 8:15 p.m., " At approximately 6:45 p.m. resident was in game room with staff and other residents. Resident #200 got up and started walking so certified staff held his/her hands to guide him/her back to his/her chair. Resident let go of staff ' s hands and slapped resident #600 on the back. Resident #200 then started to charge at resident #800 and hit him/her on back so certified staff yelled for help. I arrived and

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immediately removed resident from gam room. Resident #200 taken to his/her room and placed in recliner. I sat in a chair next to resident ' s door. Left message for regional nurse and contacted physician while operator sat with resident. Received a call to send resident to hospital behavior unit for evaluation and admit. Emergency Medical Services (EMS) called. Two cops arrived first then EMS arrived. Left message for spouse. " Signed licensed nurse D.

Note: Functional capacity screen dated 1-22-15 for resident #600 recorded resident required physical assistance with transfer ambulation/mobility in wheelchair, and experienced impaired memory recall, short term memory, long term memory and decision making. Resident #600 ' s record lacked documentation of nursing assessment following the incident.

Note: Functional capacity screen dated 2-21-14 for resident #900 recorded resident independent with transfer, assist with ambulation, self-propelled while in wheelchair, experienced impaired memory recall, short term memory, long term memory, and decision making, and identified falls/unsteadiness as a current or recent problem. Resident #900 ' s record lacked documentation of nursing assessment following the incident.

Written witness statement from operator dated 4-13-15 at 3:12 recorded " resident #200 was in the game room when he/she became agitated that resident #600 was being loud and resident #200 hit him/her on the back and while staff escorting resident #200 out of area he/she slapped resident #800. The operator was on the phone trying to get a sitter when this happened.

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S3028	Continued From page 17 Licensed nurse A came to the game room and helped escort resident #200 back to his/her room. Licensed nurse A sat with resident until I could get down to room. At that time licensed nurse a left to notify the physician and I sat with resident until the police and EMS arrived. EMS asked if they could bring him/her back and I told them they would have to assess resident first but probably would not be able to accept him/her back. " Telephone interview on 4-13-15 at 11:30 a.m. with family member for resident #100 stated he/she was going to move resident #100 due to resident #200 going around facility pushing and hitting residents and staff. He/she did not feel (resident #100) or any other residents were safe and management refused to do anything about resident #200 ' s behaviors. Resident #100 has to keep door locked at all times due to fear of resident #200 coming back to his/her room. Resident #100 will not open door unless staff states who they are. Staff to escort resident #100 to dining room and back. Resident will have to stay in his/her room due to fear of resident #200. Family member further states had observed other incidents with resident #200 holding onto resident #900 ' s wheelchair and he/she was crying and (family member) stopped resident #200 from holding onto him/her. Resident #200 took walker from resident #100 ' s spouse (prior to passing) and laid down across hallway so no one could get by him/her. Staff had to take walker from him/her. Resident #200 was hitting staff, aggressive and abusive. Written witness statement from certified staff O dated 4-14-15 at 12:10 p.m. recorded " resident #200 has pulled other residents hair, punched resident #600 and #800 in the back, hit my arm, and grabbed me. "	S3028		

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S3028	Continued From page 18 Written witness statement from certified staff H dated 4-14-15 at 1:00 p.m. recorded " there have different instances in which I have witnessed resident #200 being aggressive with other residents and employees. I (observed) him/her walk up to resident #900 and just grab their wrist and start twisting. I have tried to redirect him/her and he/she will grab your wrist and twist it. He/she has done that to me and it took another staff member to get resident to let go. Resident #200 has raised his/her fist to me at one point and lunged toward me like he was going to punch me. Resident #200 had moments when he/she would walk by you and just smack you on the arm. " Written witness statement from certified staff N dated 4-14-15 at 1:00 p.m. recorded " there has been several occasions when I have seen resident #200 being aggressive with staff and residents. In the mornings I would give him/her medications and some days were not so easy. He/she would kick at me or try to grab my arm. I also seen him/her hit resident #400 and squeeze his/her arm so tight that it caused a bruise. " Written witness statement from certified staff M dated 4-14-15 at 1:11 p.m. recorded " resident #200 has punched many residents, twisted resident #400 ' s arm, physically hit me on several occasions by kicking, punching and scratching. Punch a resident here for day care, many staff and residents have been assaulted, resident #400 was pulled out of bed, residents and staff do not feel safe. " Written witness statement from certified staff C at 1:50 p.m. on 4-14-25 recorded, " I was in the	S3028		

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S3028	Continued From page 19 dining room when I saw (resident #200) try to sit on side of chair and I said let me move you over so we can sit right in the chair. (Resident #200) grabbed my forearm and squeezed it had and start shaking it and using other arm to try and hit me in the head. Another staff member moved the chair behind him/her so he/she could sit down and not hurt anyone else. I had a bruise on my forearm shaped like his/her hand print for a week. " Written witness statement from certified staff P at 3:05 p.m. on 4-14-15 recorded " resident #200 would raise his/her voice and his/her hand at staff and on one occasion he/she hit me and I filled out the paperwork and notified charge nurse. On another occasion, I was ambulating another resident with another staff member and we walked past resident #200 who got angry and grabbed the resident #700 ' s arm pretty hard. We got the two residents separated and notified the charge nurse and licensed nurse A. On another occasion, resident pushed resident #100 onto the ground. I heard yelling and went to resident #100 ' s room and found resident #100 on the floor. Resident #100 told us that resident #200 pushed him/her on the floor. The charge nurse was notified. ' On 4-9-15 at 5:15 p.m., Operator provided a completed facility report form that recorded Plan: associates are doing hourly checks on resident #200 to ensure his/her safety and other residents ' safety. Spouse sitting with resident during evenings after meals. We are escorting resident back to his/her room to ensure there is not mix up when trying to find room. Associates are to know and watch resident #200 at all times while out of room.	S3028		

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S3028	Continued From page 20 On 4-9-15 at 5:17 p.m. requested a written statement of how they are going to ensure this resident is observed at all times when out of his/her room. On 4-9-15 at 5:45 p.m. received a written statement from the operator that recorded: " currently working to find a proper placement while resident #200 is still in community. Our interventions are to do hourly checks on resident while in room. After meals we are escorting resident #200 back to his/her room to ensure there is not mix up of room. When resident is out of room associates to stay with resident at all times. Maintenance will put laser lights in room to know when resident is up and a monitor so associates can hear resident. An associate will be with resident while out of room. Going to provide a sitter until we are able to add monitor and laser light. Operator and licensed nurse A to stay with resident until sitter is available. " For resident #200, the operator failed to report allegations of abuse/neglect to the department within 24 hours, start an investigations, implement immediate measure to prevent further potential abuse/neglect, thoroughtly investigate within 5 working day of the initial report, take corrective action, submit the department's complaint investigation repport within 5 working days, and a written record shall be maintained of each investigation of reported abuse or neglect.	S3028		
S3065 SS=J	26-41-200 (a) Resident Criteria (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development and implementation of written admission, transfer, and discharge	S3065		

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policies that protect the rights of each resident, pursuant to K.A.R. 26-39-102. In addition, the administrator or operator shall ensure that any resident who has one or more of the following conditions is not admitted or retained unless the negotiated service agreement includes services sufficient to meet the needs of the resident:
(1) Incontinence, if the resident cannot or will not participate in management of the problem;
(2) immobility, if the resident is totally dependent on another person ' s assistance to exit the building;
(3) any ongoing condition requiring two or more persons to physically assist the resident;
(4) any ongoing, skilled nursing intervention needed 24 hours a day; or
(5) any behavioral symptom that exceeds manageability.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-200(a)(5)

The facility identified a census of 26 residents. The sample included 3 residents and 6 focus review residents. Based on record review, interviews, and observations for 1 (#200) of 3 residents sampled, the operator failed to ensure residents with behavior symptoms that exceed manageability were not retained when staff identified evidence that resident #200 began aggressive behaviors toward staff the day following admission, grabbed, hit, or punched residents on at least 5 occasions between 3-2-15 and 3-17-15; on 4-7-15 #200 knocked a resident down and placed his/her foot on the resident ' s head to hold him/her down causing bleeding from nose and face with bruising to face and knees. These failures placed all residents in the facility in

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S3065	Continued From page 22 immediate jeopardy for harm or injury. Findings included: - Record review for resident #200 revealed an admit date of 2-16-15 with diagnoses of organic dementia, depression with anxiety, hypertension, and osteoarthritis. The functional capacity screen (FCS) date 2-17-15 recorded resident independent with transfer, walking/mobility and did not exhibit socially inappropriate behaviors. The FCS also recorded resident required physical assistance with bathing dressing, toileting, eating, management of medications/treatments, bladder incontinence, experienced short-term memory loss, long-term memory loss, memory recall, decision making, impaired decision making, falls/unsteadiness, and wandering. The Negotiated Service Agreement (NSA) dated 2-17-15 recorded resident required physical assistance with bathing, dressing, toileting, eating, staff to administer medications/treatments. Resident is incontinent of bowel and bladder, independent with all transfer and mobility. Resident needs redirection to the dining room for meals and to game room for activities. Resident has memory impairment, wanders and requires redirection. Resident is not oriented to person place and time. Resident has difficulty communicating needs, preferences, and wanders throughout the facility down the halls and in common areas. Resident is easily redirected. Resident demonstrates reluctance for . . accepting care, is combative at times and starts breathing heavily before becomes combative. When resident non-compliant or	S3065		

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combative, staff is to step away and re-approach at a later time.

The NSA lacked revision to address aggressive behaviors or difficulty redirecting, hitting, kicking, pushing, and grabbing other residents and staff.

Resident #200 ' s log notes recorded the following:

2-17-15 at 4:00 p.m., " Resident walking halls most of time. . .Resident did show combative behaviors when staff approached to try and toilet resident. Resident is not oriented to person, place, or time. Resident ' s spouse stated this is the behaviors resident had at home. " Signed licensed nurse L.

2-18-15 at 6:40 a.m., " . . .Resident redirected throughout night to room. On resident ' s last check and change (resident) charged at this nurse and attempted to hit when assisting him/her to bed. Attempted to administer Ativan as needed (for anxiety) and resident refused. " Signed licensed nurse E.

2-21-15 at 7:15 a.m., " Resident charged this nurse and two other staff members with a chair. Resident attempted to enter into other residents rooms. Resident does not take re-direction well and attempts to hit staff with open hand. New order for Ativan topical every 6 hours for anxiety. " Signed licensed nurse B.

3-2-15 at 4:30 p.m., " Resident #200 grabbed resident #400 ' s hand squeezing it very tight causing the resident to scream, associates intervened and got resident #200 to free resident #400 ' s hand. Resident taken to dinner and attempting to hit associates while being seated. "

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S3065	Continued From page 24 Signed licensed nurse A. Note: Negotiated service agreement dated 6-25-14 for resident #400 recorded resident independent with ambulation using for wheeled walker. Resident very pleasant and social. Resident has memory and decision making impairment, short and long term memory loss with impaired decision making. Resident #400 ' s record lacked documentation of assessment following 3-2-15 altercation with #200. Resident #200 ' s log notes further recorded: 3-3-15 at 11:30 a.m., Resident very resistive to care and combative with associates. Multiple attempts to re-direct resident were unsuccessful, resident remained combative and agitated. Signed licensed nurse A. 3-4-15 at 6:50 p.m., " Resident displayed severe aggression towards staff during life enrichment activity. " Signed licensed nurse D. 3-9-15 at 6:50 p.m., " Resident ambulating throughout community with unsteady gait, refused staff assistance. Resident continued to display combative behaviors towards staff and residents. Resident redirected several times. " Signed licensed nurse D. 3-14-15 at 7:58 p.m., " Resident is re-directed as he/she is in another resident ' s room lying on floor. Resident became combative with staff by hitting, punching, squeezing fingers, bending arms, and running. " Signed licensed nurse D. 3-14-15 at 8:50 p.m., " Resident refused to leave other residents alone and continued to hit staff when re-directed. " Signed licensed nurse D.	S3065		

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3-15-15 at 4:20 p.m., " Resident became combative with another resident #700 by twisting his/her arm. Resident refuses to ambulate to activity without hitting staff. " Signed Licensed nurse D.

Note: functional capacity screen dated 1-22-15 for resident #700 recorded resident independent with ambulation, experienced short term memory loss, long term memory loss, memory recall and impaired decision making. Resident was not at risk for wandering or falls/unsteadiness. Resident #700 ' s resident log notes lacked documentation of an assessment at the time of the incident; entry dated 3-16-15 at 4:10 p.m. recorded resident ambulating halls without difficulty. Resident has a large dark purple bruise to right posterior forearm, large purple bruise to right hand, dime size bruise to left hand, and approximately bigger than a quarter size bruise to left hand that looks old. Signed licensed nurse A.

Resident #200 ' s log notes further recorded: 3-16-15 at 4:30 p.m., " Around 1:45 p.m. this resident became aggressive with another resident #500 after he/she tried to hold his/her hand. This resident hit him/her on the left side of his/her back and pulled his/her hair. Associate intervened and separated them. Multiple attempts to redirect were unsuccessful. Resident hitting out at associates. Ativan was given. " Signed licensed nurse A.

3-17-15 at 12:30 p.m., " . . . Resident kicks and hits staff. Resident allowed to ambulate without shoes to enhance safety. " Signed licensed nurse D.

4-7-15 at 3:45 p.m., " Called to resident room by certified staff who heard screaming noise and

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found resident #200 in resident #100 ' s room sitting in the recliner. Physician notified of resident #200 ' s behavior. Resident is monitored by staff at all times, staff continue to close all room doors to ensure safety of all residents. " Signed licensed nurse D.

Review of resident #100 ' s record at 4:20 p.m. revealed an admit date of 9-17-14 with diagnoses of non-insulin dependent diabetic and arthritis. The Functional Capacity Screen (FCS) dated 9 2-24-15 recorded resident was independent with transfer, walking/mobility and had occasional short term memory loss. The FCS dated 2-24-15 recorded resident not at risk for falls/unsteadiness and does not experience impaired decision making.

Interview on 4-9-15 at 3:35 p.m. with resident #100 stated he/she " moved here with his/her spouse who passed away last week. Resident stated resident #200 opened his/her door and came in while he/she was sitting in recliner. He/she got up and told resident #200 this was not his/her room and to leave. He/she turned around and asked him/her to leave and walked towards the door and resident #200 pushed him/her down to the ground where he/she fell face first to the floor. Resident #200 put his/her foot over (resident #100 ' s) head to keep resident down on floor and told him/her to shut up. Resident #100 started screaming as loud as he/she could and staff came to room to get resident out his/her room. Resident #100 was bleeding from nose and small area at bridge of nose where glasses was. " Observed red spots the size of an open hand on floor where resident stated he/she fell. Resident #100 stated that was his/her blood from the fall. Resident #100 further stated the facility called EMS and 911. Police arrived prior to EMS

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arriving. Family member arrived prior to EMS/police leaving. EMS assessed resident #100 who declined going to the Emergency Room at this time.
Observed purple bruising around nose, left eye, left cheek from eye down to under neck. Bruising also noted to right and left knee approximately 3 centimeter circle purple in color. .

Interview on 4-9-15 at 2:38 p.m. with operator stated, resident #100 was pushed down by resident #200 who has impaired memory. Resident #100 has bruising on face, left cheek, eye and nose. 911 was called and police came and did a police report. Family (for resident #100) was upset and felt resident #200 was stalking resident #100. Further stated resident #200 does grab other residents and staff. He/she has grabbed other resident ' s wrist and he/she is a big person.

Resident #200 ' s log notes further recorded: 4-9-15 at 6:00 p.m., " Licensed nurse A called an outside agency that provided 24 hour sitter due to resident #200 ' s previous aggression towards resident #100. The agency will send a sitter this evening. " Signed licensed nurse A.

4-9-15 at 8:15 p.m., " At approximately 6:45 p.m. resident was in game room with staff and other residents. Resident #200 got up and started walking so certified staff held his/her hands to guide him/her back to his/her chair. Resident let go of staff ' s hands and slapped resident #600 on the back. Resident #200 then started to charge at resident #800 and hit him/her on back so certified staff yelled for help. I arrived and immediately removed resident from gam room. Resident #200 taken to his/her room and placed in recliner. I sat in a chair next to resident ' s

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door. Left message for regional nurse and contacted physician while operator sat with resident. Received a call to send resident to hospital behavior unit for evaluation and admit. Emergency Medical Services (EMS) called. Two cops arrived first then EMS arrived. Left message for spouse. " Signed licensed nurse D.

Note: Functional capacity screen dated 1-22-15 for resident #600 recorded resident required physical assistance with transfer ambulation/mobility in wheelchair, and experienced impaired memory recall, short term memory, long term memory and decision making. Resident #600 ' s record lacked documentation of nursing assessment following the incident.

Note: Functional capacity screen dated 2-21-14 for resident #900 recorded resident independent with transfer, assist with ambulation, self-propelled while in wheelchair, experienced impaired memory recall, short term memory, long term memory, and decision making, and identified falls/unsteadiness as a current or recent problem. Resident #900 ' s record lacked documentation of nursing assessment following the incident.

Written witness statement from operator dated 4-13-15 at 3:12 recorded " resident #200 was in the game room when he/she became agitated that resident #600 was being loud and resident #200 hit him/her on the back and while staff escorting resident #200 out of area he/she slapped resident #800. The operator was on the phone trying to get a sitter when this happened. Licensed nurse A came to the game room and helped escort resident #200 back to his/her room. Licensed nurse A sat with resident until I could get

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down to room. At that time licensed nurse a left to notify the physician and I sat with resident until the police and EMS arrived. EMS asked if they could bring him/her back and I told them they would have to assess resident first but probably would not be able to accept him/her back. "

Telephone interview on 4-13-15 at 11:30 a.m. with family member for resident #100 stated he/she was going to move resident #100 due to resident #200 going around facility pushing and hitting residents and staff. He/she did not feel (resident #100) or any other residents were safe and management refused to do anything about resident #200 ' s behaviors. Resident #100 has to keep door locked at all times due to fear of resident #200 coming back to his/her room. Resident #100 will not open door unless staff states who they are. Staff to escort resident #100 to dining room and back. Resident will have to stay in his/her room due to fear of resident #200. Family member further states had observed other incidents with resident #200 holding onto resident #900 ' s wheelchair and he/she was crying and (family member) stopped resident #200 from holding onto him/her. Resident #200 took walker from resident #100 ' s spouse (prior to passing) and laid down across hallway so no one could get by him/her. Staff had to take walker from him/her. Resident #200 was hitting staff, aggressive and abusive.

Written witness statement from certified staff O dated 4-14-15 at 12:10 p.m. recorded " resident #200 has pulled other residents hair, punched resident #600 and #800 in the back, hit my arm, and grabbed me. "

Written witness statement from certified staff H dated 4-14-15 at 1:00 p.m. recorded " there have

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different instances in which I have witnessed resident #200 being aggressive with other residents and employees. I (observed) him/her walk up to resident #900 and just grab their wrist and start twisting. I have tried to redirect him/her and he/she will grab your wrist and twist it. He/she has done that to me and it took another staff member to get resident to let go. Resident #200 has raised his/her fist to me at one point and lunged toward me like he was going to punch me. Resident #200 had moments when he/she would walk by you and just smack you on the arm. "

Written witness statement from certified staff N dated 4-14-15 at 1:00 p.m. recorded " there has been several occasions when I have seen resident #200 being aggressive with staff and residents. In the mornings I would give him/her medications and some days were not so easy. He/she would kick at me or try to grab my arm. I also seen him/her hit resident #400 and squeeze his/her arm so tight that it caused a bruise. "

Written witness statement from certified staff M dated 4-14-15 at 1:11 p.m. recorded " resident #200 has punched many residents, twisted resident #400 ' s arm, physically hit me on several occasions by kicking, punching and scratching. Punch a resident here for day care, many staff and residents have been assaulted, resident #400 was pulled out of bed, residents and staff do not feel safe. "

Written witness statement from certified staff C at 1:50 p.m. on 4-14-25 recorded, " I was in the dining room when I saw (resident #200) try to sit on side of chair and I said let me move you over so we can sit right in the chair. (Resident #200)

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grabbed my forearm and squeezed it had and start shaking it and using other arm to try and hit me in the head. Another staff member moved the chair behind him/her so he/she could sit down and not hurt anyone else. I had a bruise on my forearm shaped like his/her hand print for a week. "

Written witness statement from certified staff P at 3:05 p.m. on 4-14-15 recorded " resident #200 would raise his/her voice and his/her hand at staff and on one occasion he/she hit me and I filled out the paperwork and notified charge nurse. On another occasion, I was ambulating another resident with another staff member and we walked past resident #200 who got angry and grabbed the resident #700 ' s arm pretty hard. We got the two residents separated and notified the charge nurse and licensed nurse A. On another occasion, resident pushed resident #100 onto the ground. I heard yelling and went to resident #100 ' s room and found resident #100 on the floor. Resident #100 told us that resident #200 pushed him/her on the floor. The charge nurse was notified. '

On 4-9-15 at 5:15 p.m., Operator provided a completed facility report form that recorded Plan: associates are doing hourly checks on resident #200 to ensure his/her safety and other residents ' safety. Spouse sitting with resident during evenings after meals. We are escorting resident back to his/her room to ensure there is not mix up when trying to find room. Associates are to know and watch resident #200 at all times while out of room.

On 4-9-15 at 5:17 p.m. requested a written statement of how they are going to ensure this resident is observed at all times when out of

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S3065	Continued From page 32 his/her room. On 4-9-15 at 5:45 p.m. received a written statement from the operator that recorded: " currently working to find a proper placement while resident #200 is still in community. Our interventions are to do hourly checks on resident while in room. After meals we are escorting resident #200 back to his/her room to ensure there is not mix up of room. When resident is out of room associates to stay with resident at all times. Maintenance will put laser lights in room to know when resident is up and a monitor so associates can hear resident. An associate will be with resident while out of room. Going to provide a sitter until we are able to add monitor and laser light. Operator and licensed nurse A to stay with resident until sitter is available. " For resident #200, the operator failed to ensure residents with behavior symptoms that exceed manageability were not retained when resident #200 began aggressive behaviors toward staff the day following admission, grabbed, hit, or punched residents on at least 5 occasions between 3-2-15 and 3-17-15; on 4-7-15 knocked a resident down and placed his/her foot on the resident ' s head to hold him/her down causing bleeding from nose and face with bruising to face and knees and hit two residents on 4-9-15 after the facility implemented one on one staff care. These failures placed all residents in the facility in immediate jeopardy for harm or injury. The jeopardy was removed when the resident was transferred to the behavior unit on 4-9-15.	S3065		